Stated Meeting, November 9, 1904.

GEORGE WOOLSEY, M.D., in the Chair.

NECROSIS OF INTESTINE FOLLOWING TRAUMATISM AND LOCAL SEPTIC PERITONITIS.

DR. JOHN A. HARTWELL presented a man of forty-five years who was admitted to the Hudson Street Hospital on June 19, 1904. He was brought to the hospital by ambulance, having been found in a stuporous condition in the street. On the following day he stated that he had been sick for three days with epigastric pain, vomiting, and constipation. He denied all history of a trauma, but as he showed marked evidences of alcoholism, this statement counted for nothing. On admission he had a temperature of 100° F.; pulse, 84; respirations, 52. The abdomen was rigid and tender, particularly in the epigastrium. Otherwise the examination revealed nothing abnormal. An operation was done a few hours later by Dr. Benjamin T. Tilton. Through a median incision below the umbilicus the peritoneum was opened, and the abdominal cavity was found to contain a large quantity of sanguinopurulent fluid. There was considerable contusion of the mesentery, with a rupture of one or two vessels, which were still bleeding. A contusion of the jejunum extending over an area of about one foot was also present, and in one or two places the external coats of the intestine were torn through, leaving the mucous coat intact. Over these exposed areas the peritoneum was brought together with Lembert sutures, the bleeding vessels in the mesentery were ligated, and the rent in the mesentery sutured. The question of resecting the gut was decided in the negative, in the hope that it would recover, and after cleansing the cavity the wound was closed, with drainage. The intestine remained intact for one week, when a fæcal fistula formed. This failed to close, and the patient's poor condition precluded further operative measures at that time. He became septic, and developed a large abdominal abscess near the wound, and others in the ischiorectal region, and later in the scrotum. These were all suc-

cessfully treated, and he began to gain, despite the fistula high up in the intestine.

On August 7 of the present year the patient was referred to Dr. Hartwell at Bellevue Hospital, through the courtesy of Dr. Bolton, for the purpose of closing the fæcal fistula when his condition would warrant it. After two weeks of rectal feeding and careful attention to the abdominal wound, during which period the patient had continued to improve, an operation for closing the fistula was undertaken. At this time the septic condition had entirely disappeared.

The usual elliptical incision was made around the intestinal opening into the peritoneum through comparatively healthy parietes. The intestine was found to be completely divided transversely, with the proximal end projecting through the skin, and the distal end buried and occluded by a mass of adhesions inside the peritoneal cavity. The two ends were freed, freshened for a short distance, and sutured by two rows of Lembert sutures. In an attempt to break up the adhesions, a rupture was made in the gut about six inches below this point, and this was closed in the same manner. An examination of the intestine above the first division showed a length of about four inches, matted in adhesions, that was on the verge of complete necrosis, and the slightest handling of which produced a tear through the whole thickness of the wall. This peculiar condition had evidently existed for more than two months, that is, from shortly after the occurrence of the original injury. The damaged gut was resected for a distance of five inches in the usual manner, and an end-to-end anastomosis made with simple Lembert sutures.

The patient's further convalescence was uneventful. The bowels moved spontaneously on the third day, and there was never any discharge of fæces from the wound. He was fed entirely by rectum for four days, when diet by mouth was instituted and gradually increased. The interesting factor in the case was the failure of the intestine to either recover completely its circulation and vitality or to become gangrenous within a short time after the injury, and the associated peritonitis. Neither of these conditions developed, but a progressive necrotic process ensued, which sooner or later must have ended in gangrene had the affected portion not been resected.

Dr. Benjamin T. Tilton said that when the patient first

came to the Hudson Street Hospital he showed very few of the symptoms that were usually associated with injury of the abdominal viscera. He had been on a spree for two weeks, and denied all knowledge of any injury. He complained of pain in the abdomen, which he stated had come on about four days ago. The mild temperature elevation and the rapid breathing were attributed to a pleurisy, with slight effusion which was present. A rectal examination, however, revealed a mass which upon opening the abdomen proved to be due to an agglutination of the intestines. The latter were covered with lymph. Further inspection showed a contusion of the jejunum at several points and a rupture of one of the branches of the mesenteric artery, which was tied. The patient's condition at that time was so poor that an anastomosis was not deemed advisable. Perforation of the gut was feared, and subsequently it occurred, resulting in a fæcal fistula.

RUPTURE OF THE PLEURA AND LIVER.

Dr. Forbes Hawkes presented a girl, eight years old, who first came under his observation on October 5, 1903. The history obtained was that forty-three hours previous to that date the child had been run over by a wagon, one of the wheels passing over the lower part of the chest. The injury at first was not regarded as serious, for she apparently recovered from her shock shortly; but the symptoms then gradually became worse, and when Dr. Hawkes saw her the pulse was weak and rapid (120–130); she was somewhat anæmic; there was an ecchymosis over the right chest, and both recti muscles were fairly rigid. The abdomen evidently contained some fluid. There was slight dulness over lower part of right chest. A provisional diagnosis of rupture of the liver and hæmorrhage into the peritoneal cavity was made, and the abdomen was opened directly over the region of the gall-bladder. The peritoneal cavity was filled with blood-clots and a brownish-green fluid, showing the presence of bile. Further examination revealed a rupture of the liver into which three fingers could be inserted. This wound was still bleeding, and in order to check the hæmorrhage a large dry pad was introduced and pressure exerted for about five minutes. A cigarette drain wrapped with rubber tissue was then inserted down to the wound in the liver.